Healthcare Transformation Collaboratives Cover Sheet

1. Collaboration Name: Maternal Child Health + Wellness Center Transformational Collaborative

2. Name of Lead Entity: Family Christian Health Center

3. List All Collaboration Members:

1. Family Christian Health Center
2. Christian Community Health Center
3. University of Chicago Medicine - Ingalls Memorial Hospital

4. Proposed Coverage Area: Family Christian Health Center (FCHC) is located within Illinois Hospital Planning Area A-04 but has patients that also span across Illinois Hospital Planning Area A-03; Suburban Cook; NE Will Counties

5. Area of Focus: Maternal and Child Health, Equity & Improving Community Placement

6. Total Budget Requested: $24,440,349

Healthcare Transformation Collaboratives

Maternal Child Health + Wellness Center

Transformational Collaborative

Application for Submission

November 2021

Application for Submission

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Maternal Child Health + Wellness Center

Transformational Collaborative

UChicago Medicine Ingalls Memorial

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Executive Summary

Provide a narrative description of your overall project, explaining what makes it transformational. Specify your service area, identify the healthcare challenges it faces, and articulate your goals in addressing these challenges; explain your strategy and how it addresses the causes of these challenges, and lay out the expected timeframe of the project. Describe any capital improvements, new interventions, delivery redesign, etc. Your narrative should explain the need for each significant item in your budget, clarifying how each connects to the overall goals and operations of the collaboration.

To many individuals, "suburbs" suggests wealth and affluence. However, there are 16.9 million Americans living in poverty in the suburbs—more than in cities or rural communities. Despite the rise in suburban poverty, there has been little research into health care barriers faced by residents in these areas.

Family Christian Health Center, a federally qualified health center located in Harvey, Illinois has witnessed first-hand, the migration pattern of the Southland communities since the year 2000 when the health center was founded. The problems that existed 20 years ago have been exacerbated by the demolition of Chicago's public housing. In February 2020, Dr. Lisa Green, along with a group of Black women physicians and nonprofit leaders began addressing health disparities and unique challenges of the birthing population on the South Side of Chicago and South Suburban Cook County; amid an alarming trend of hospitals discontinuing inpatient obstetric services and an unprecedented global pandemic. Family Christian Health Center (FCHC) is located within Illinois Hospital Planning Area A-04 but has patients that also span across Illinois Hospital Planning Area A-03, as it services nearly 20,000 patients across 59 zip codes. Since 2019, residents living in both hospital planning areas have experienced the discontinuation of labor and delivery services in four hospitals impacting over 300,000 reproductive age persons residing in those regions. For the city of Harvey there are no perinatologists or neonatologists. High-risk pregnant patients must travel between 10 to 24 miles to receive advanced maternal care or neonatal care for infants.

This proposal seeks $24M for five years of transformational funding to strengthen services through staffing and the development of a mobile application (MHealth solutions) within a newly created standalone Maternal Child Health + Wellness Center. This proposal is transformational and relevant to public health and health services in Illinois by addressing: a) the profound historical and systemic healthcare gaps contributing to Illinois being ranked 33rd out of 50 states in maternal and infant mortality (Maternal Health); b) brings together a network of medical services and direct outreach care to manage and reduce high-risk pregnancies both "upstream" and immediately following delivery (Maternal Health); c) brings services needed to address emergency and transitional housing, substance abuse, and postpartum depression and prenatal emotional distress (Mental Health Parity); d) develops a scalable model of care coordination, data and surveillance for measuring impact, and population health information technology (Access and Health Equity). As a means for enhancing healthcare delivery through telecommunications

devices, telehealth encompasses multiple healthcare disciplines, including maternal and child health. It includes live videoconferencing as well as remote patient monitoring and mobile health (mHealth). The greatest benefit of telehealth is expanded access to care, particularly for patients in poor, isolated and geographically segregated locations who must otherwise travel extended distances for care. Other benefits include cost savings, improved workflows, enhanced communication between the clinician and patient, and improved health literacy and patient self-management with physician feedback.

The MHealth application (app) will close the technology and innovation equity gap by bringing preventive care, prenatal care, postnatal care, and family system supports right into the palm of patients' hands. The application will allow patients to connect with obstetrics and pediatrics, postpartum care, mental and behavioral health (including grief and loss counseling), pharmacy, benefits and family planning, food and nutrition and emergency and permanent housing right from their smartphone, tablet, and other mobile device.

The advances in mobile technologies and applications are driving the transformation in health services delivery globally. Our communities cannot afford to be left behind on technological investment, innovation, and use.

Our request includes transformation funding to support the addition of medical staff, clinical care assistants, community health workers, housing liaisons, and workforce support. We are requesting urgently needed funding for strengthened family systems, birthing, clinical practice, counseling, postpartum care, pediatric and social services. During the pandemic, critical gaps in maternal and childcare widened significantly. Family Christian Health Center responded by raising funds through donations to launch Maternal Child Health + Wellness Center at the Chicago Medicine-Ingalls Memorial Hospital site. FCHC Maternal Child Health + Wellness Center provides maternal health (prenatal, postnatal care, diagnostics, and centering) for more than 8,000 patients from across Southern Cook and Will counties. FCHC was successful at providing not only maternal health care, but also meals, testing, transportation support, counseling, and family systems services. However, there remains a significant gap in coverage for these services with an additional service capacity need for 15,000 more patients.

FCHC immediately engaged and rallied partners together to develop Maternal-Fetal Medicine (MFM) services and a coordinated community support initiative to locate mothers at-risk and provide wrap-around services addressing social determinants of health. Our proposal builds the community workforce, adding more providers to prevent and treat high-risk pregnancies. We are also addressing inequities in access to technology and health information for advancing innovative population health interventions.

Family Christian Health Center will serve as the lead recipient and lead organization coordinating hiring, training, billing, accounting, and reporting. No new entities are being formed. Over a five-year period, we anticipate that we will produce results that improved the value of maternal outcomes per dollar, reduced emergency room visits, and significantly reduced both maternal and infant mortality across South Suburban Cook (EAST to Indiana border neighborhoods and townships) and Will Counties (WEST I-57/I-80/I-294 corridor to Tinley Park, Matteson, University Park).

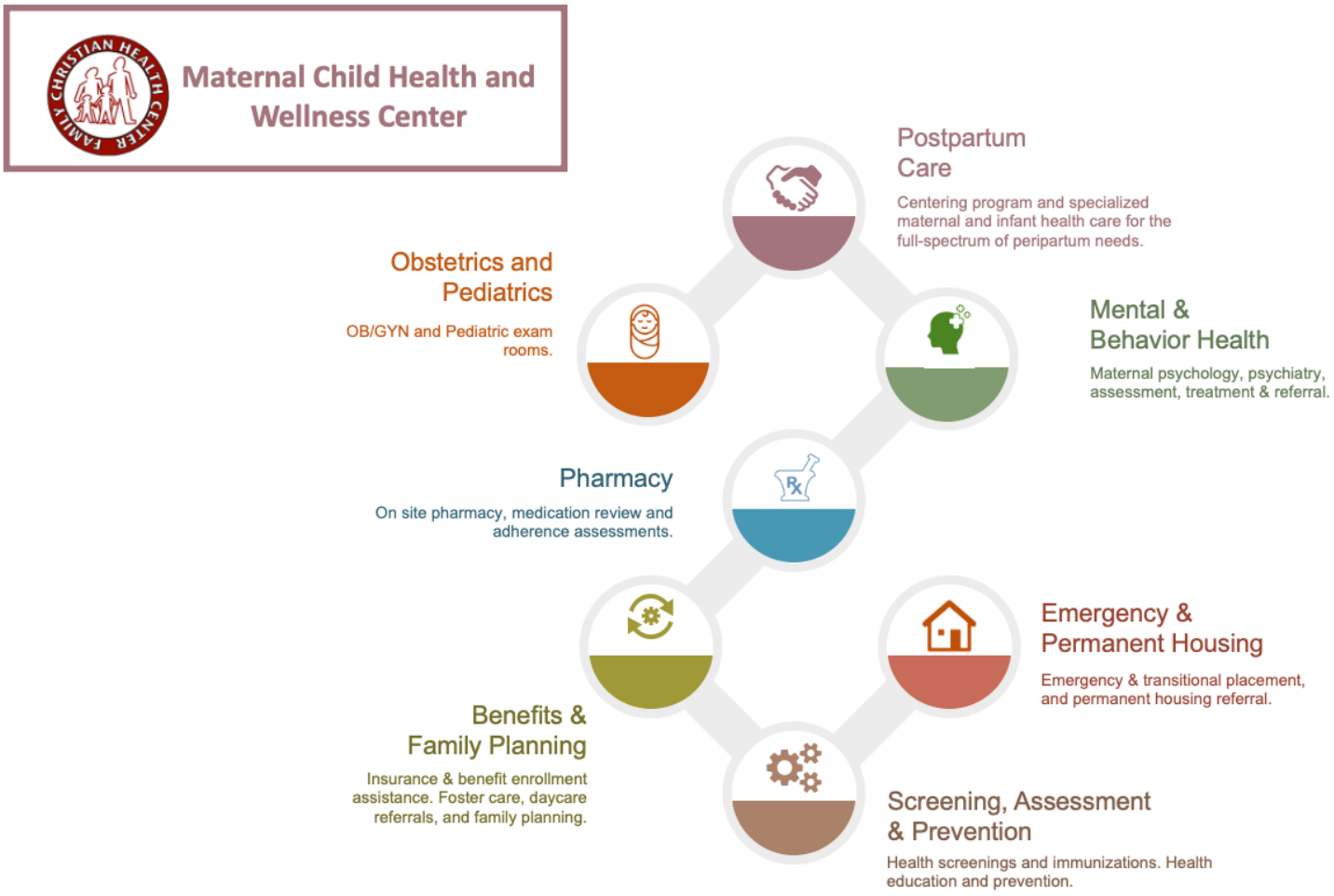
As depicted below in Figure 1, in **partnership with the University of Chicago and its Maternal and Fetal Medicine (MFM) Team, the FCHC Maternal Child Health + Wellness Center Transformational Collaborative (MCHWCTC) currently provides**:

1) **Obstetrics and Pediatrics**. Strengthen the perinatal health care delivery system in South Suburban Cook and Will counties. Specifically, expanding the FCHC MCH model to include maternal-fetal medicine, ancillary services, midwife services, and prenatal and postpartum home health care.
2) **Antepartum / Postpartum Care**. Centering program and specialized maternal and infant health care for the full spectrum of peripartum needs. Improve the workforce pipeline of racially concordant healthcare workers by scaling the FQHC internship model and integrating an on-site family practice residency program.
3) **Mental & Behavioral Health**. Maternal psychology, psychiatry, assessment, treatment, and referral. Reduce maternal health disparities contributed by psychosocial stress especially those in immediate need of grief / bereavement care for miscarriage, stillbirth, or infant loss. Supportive care for reproductive planning, families with a baby in the NIC-U, and processing a traumatic birth experience.
4) **Pharmacy**. On-site pharmacy, medication review and adherence assessments.
5) **Benefits & Family Planning**. Insurance and benefit enrollment assistance. Foster care, daycare referrals, and family planning.
6) **Screening, Assessment & Prevention**. Health screenings and immunizations. Health education and prevention. Implement health informatics and management, integrate a mobile health platform to improve care coordination, increase data surveillance, data collection, and reporting of infant and maternal health outcomes for South Suburban Cook County
7) **Emergency & Permanent Housing**. **In partnership with Christian Community Health Center (CCHC)** provide emergency and transitional placement and permanent housing referral. Collaborating with an established and respected healthcare and housing health center to provide temporary and crisis housing, while preparing long-term housing solutions.

Mobile Application for Family Systems, Birthing and Nurturing Connectivity

The pandemic of 2020 demonstrated the significant vulnerability of communities needing access to timely, accurate and trustworthy information. Anticipating this need in the community, in 2020 FCHC launched an initiative to build, integrate and use AI Ecosystem Assets into the FCHC delivery framework. Forward thinking in its scope, FCHC undertook considerable reengineering of its technology stack, expansion of its employee skill sets, regulatory enhancements, and restructuring information in workflow. The overarching objective of this effort was to prepare FCHC to utilize AI Ecosystem Assets including Conversational Computing, Intelligent Robotic Process Automation, and Machine Learning to build out a hybrid digital / human workforce capable of extending FCHCs already high quality of care at scale. To this end, FCHC has been successful in meeting these challenges. However, a significant need in technology, communication and workflow investment remains.

Figure 1: Components of FCHC Maternal and Child Wellness Center



Deliverables related to this effort include and are not limited to the following:

- Migration of relevant systems of record including the EHR from an on-premises data center to the Microsoft Azure Cloud.
- Design and build out of innovative medical informatics and data analytics and visualization team.
- Staff education concerning Agile Frameworks, Methodologies, and Business Process Model & Notation for constructing detailed AS / TO models.
- Reengineering of FCHC call center telephony platform resulting in near 100% inbound call efficiency.
- Complete revamp of HIPAA policies and procedures required to deliver healthcare within a radically decentralized wireless and mobile delivery model.

The above deliverables set the stage for FCHC to explore and engage with sophisticated strategic technology partners within the domains of computer hardware, AI, software engineering, telephony, application development and other.

To establish key strategic MCO and health systems relationships, FCHC embarked on an innovative campaign to extend its clinical delivery operations to include the utilization of AI, starting with Conversational Computing. To this end, FCHC has labored in application of five (5) AI and Healthcare Grant proposals to five distinct and highly reputable grant awarding organizations. FCHC was applauded for its work and received all five awards. These include the following:

Centene Corporation
Utilization of Conversational AI and Digital Peripherals to Enhance the Nutritional Optimization of Black Maternal Health.

Aetna Better Health of Illinois
Utilization and Expansion of a Hybrid Human & Digital Labor Behavioral and Mental Health Care Workforce in Order to Meet the Expanding Needs of Chicago Southland Patients Suffering from Anxiety Exacerbated by the COVID 19 Pandemic.

Blue Cross and Blue Shield of Illinois
Expansion of Behavioral and Mental Health Care AI Digital / Human Workforce in Order to Meet the Expanding Needs of Chicago Southland Patients Suffering from Anxiety Exacerbated by the COVID 19 Pandemic.

Direct Relief Corporation
Utilization of an AI Empowered COVID-19 Screening and Education Portal.

Federal Communications Commission (FCC) COVID-19 Telehealth Program
VoIP video phones and cloud technology to support telehealth delivery by enabling remote consultation, especially for seniors and other vulnerable populations that struggle to use more conventional smartphones.

Family Christian Health Center (FCHC) has engaged S. Vincent Grasso, DO, MSIS, MBA as Chief Technology Officer (CTO). Dr. Grasso leverages his subject matter expertise within the domains of healthcare as a physician, technology as a software architect, and business as a process / finance reengineer to optimize value contribution, market differentiation, and competitive advantage within the global public and private marketplace. Prior to this CTO role, he was instrumental in launching and building out over the past three years the Healthcare & Life Sciences Global Practice for IPsoft Inc., the world's leading private AI company, as its Global Lead. This effort involved multilingual global business development with large payer, provider, banking,

government, and consulting entities. The most compelling deliverable included the vision and actualization of hyper scale, omnichannel, multilingual, digital / human workforces based upon leveraging Conversational AI, Robotic Process Automation, and Machine Learning applications and integrations. Dr. Grasso will lead the application framework and internal billing and clinical outcomes for the FCHC Maternal Child Health + Wellness Center mobile application.

The Institute of Medicine

The MCHWCTC is collaborating with The Institute of Medicine as an authoritative advisor to key stakeholders to address the concerns of medicine and healthcare. The Cross County Maternal Health Task Force (MHTF) is a program of the Institute of Medicine of Chicago (bios attached). The Task Force would work to augment the work by expanding the collaboration past the south side of Chicago and South Suburban Cook County.

The purpose of the MHTF is to bring together experts and practitioners in maternal and child health to solve in the moment issues identified with access to appropriate service and referrals for pregnant women in Chicago. The MTHF will communicate with Medicaid managed care companies, hospitals, and providers who are receiving public dollars to facilitate and improve access to real services. The task force will look at gaps in county coverage for maternity care and work with hospitals, providers, the county, and the state to create access points that decrease stress and risk for pregnant women.

In their first meeting, the MHTF identified that the size of cuffs provided by the Medicaid health plans were of the smallest size and did not fit a number of pregnant women to whom they were provided. The MHTF notified the state, who responded promptly to require the Medicaid managed care MCOs to provide larger cuffs when requested. This is just one example of how a cross county collaborative can work in real time to identify barriers and address them. The requested funding will support a full-time staff person dedicated to documenting identified issues and working with the MHTF to follow-up and address the issues.

The MHTF is made up of professionals from managed Medicaid, retired DHS and pediatrician, Northwestern, Cook County Hospital, and fellows of the Institute of Medicine of Chicago.

Capgenus, Population Health Data Analytics

Capgenus, is a Black-owned population health and management consulting and analytics firm. Capgenus will deliver executive leadership for the entire team. The firm will lead overall design and team performance measurements and manage data and surveillance objectives. They will be responsible for outcomes reports and connecting data and gathering and analyzing data to determine the impact to the business operations. Capgenus will lead the application build and analytics (Figure 2.).

Figure 2: MHealth – Mobile application Solution (Closing Technology Equity Gaps)

FCHC remains committed to delivering high quality healthcare delivery to our patients as we have been since inception over 20 years ago. Our dedicated team recognizes that healthcare delivery over the next 10 years will be increasing digital. We also recognize that the digital migration pathway is complex and requires commitment, funding, strategic partners, and human workforce skill set expansion. FCHC recognizes that digital workforce utilization afforded by *Conversation AI* is essential to operating within an omnichannel, multilingual, 24/7 healthcare delivery model at scale.

FCHC is prepared to meet this demand afforded by the above and provide a leadership role to other FQHCs in learning and collaboration.

Timeline and Key Objectives

Goals: Develop, implement, and scale a Maternal Child Health + Wellness Center Transformational mobile health application and platform for increased access, integrated care

and quality measurement using a secure interactive mobile messaging, video, or telecommunications technology. Deliver more timely, efficient, and effective care to save maternal, fetal, and infant lives. Link practitioners and patients located at different sites while advancing models and methodologies for realized cost-savings for medically necessary mobile application and telemedicine services to eligible Medicaid members.

Objectives: FCHC is focused on value-driven rather than on volume-driven healthcare. This proposed work encompasses addressing quality issues across the spectrum of care. We aim to encourage use of technology and advance innovation among populations and geographies typically excluded from investment and support. Set improved patient outcomes as a priority across the entire system by measuring usability, user satisfaction and provider engagement. Stop outmigration of patients to adjacent states.

- The American Medical Association (AMA) released the 2020 Current Procedural Terminology (CPT®) code set containing identifiers and descriptors assigned to each medical, surgical, and diagnostic services available to patients. **Among the 2020 important additions to CPT are new medical services sparked by novel digital communication tools, such as patient portals, that allow health care professionals to connect with patients more efficiently at home and exchange information**. CPT has responded by adding six new codes to report online digital evaluation services, or e-visits. These codes describe patient-initiated digital communications provided by physician or other qualified health care professional (99421, 99422, 99423), or a non-physician health care professional (98970, 98971, 98972).

- FCHC and its collaborators seek to framework, test, and advance methodologies for adoption of reimbursement criteria (i.e., appropriate CPT or HCPCS codes) for eligible Medicaid serving healthcare providers to be compensated and incentivized for proactive use of MHealth applications and telemedicine modalities to reduce inequities in health.

- Make more consistent MHealth applications and telehealth FQHC and Medicaid reimbursement policies between Federal, State, and private payers.

- Advance new technologies for e-visits and health monitoring for identifying and leveraging best access points for specialty care, MFM and PCP physician care throughout the pregnancy and labor and delivery cycle for Medicaid eligible populations.

- Refine and make relevant for Medicaid eligible populations definitions of an originating site for a MHealth applications and telehealth services including greater flexibility for other non-traditional settings.

- Communicate with HFS, CMS and HRSA ways MHealth applications and telehealth services improve care and close equity gaps in MSA, non-MSA or Rural Health persistently experiencing healthcare professional Eligible providers (*e.g, physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, clinical psychologists, clinical social workers, registered dieticians, or nutritionist*) professional shortages.

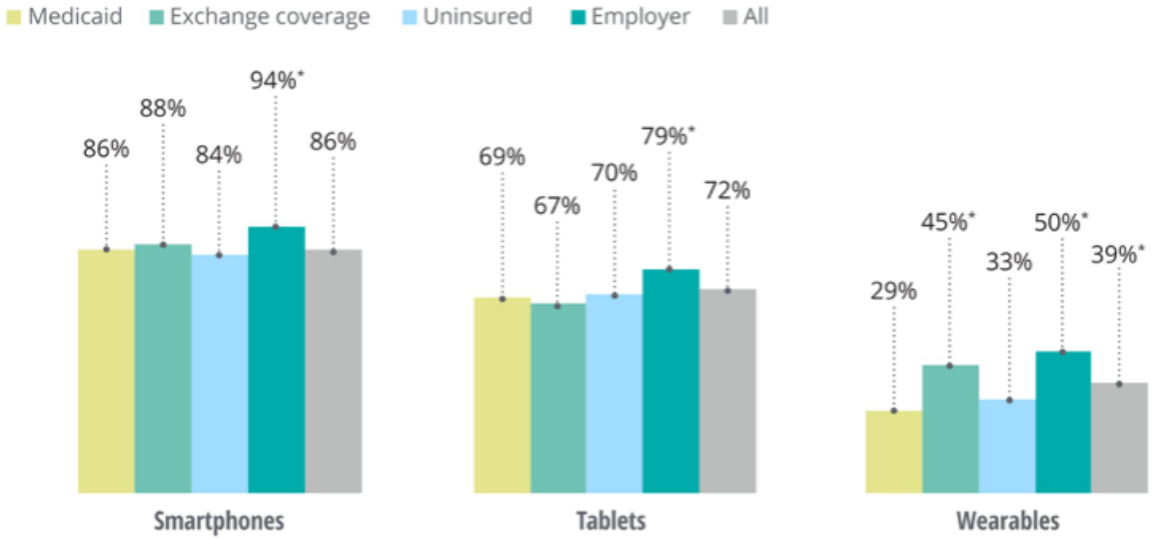
BACKGROUND AND OVERVIEW

Most adult Medicaid beneficiaries own mobile technologies, use them for a variety of health purposes, and are interested in trying new digital health applications in the future. One in five people in the United States are enrolled in Medicaid and several mobile apps on the market are designed to meet some of their diverse needs (*Deloitte Health Solutions Survey*[1]). Adult Medicaid beneficiaries differ from those with private insurance in important ways. Medicaid eligible populations typically have lower incomes, high morbidity, and mortality rates, are geographically isolated, and are more likely to have social determinant needs related to unstable housing, employment, and food security. A recent Deloitte survey highlights three important factors pertaining to Medicaid eligible populations and the adoption of digital technology, such as smartphones and tablets.

1. Adult Medicaid beneficiaries own smartphones (86 percent) and tablets (69 percent) at the same rates as the general adult U.S. population (86 percent and 72 percent, respectively), but at slightly lower rates than those with employer insurance (94 percent and 79 percent). More than one-quarter of Medicaid beneficiaries report owning wearables (29 percent), a rate lower than that of the general population (39 percent).
2. Rates of ownership and use for health of these devices continues to increase.
3. These tools have the potential to improve member engagement, care management, and the exchange of health and healthcare information between patients and providers.

[1] https://www2.deloitte.com/us/en/insights/industry/public-sector/mobile-health-care-app-features-for-patients.html

Adult Medicaid beneficiaries own smartphones and tablets at similar rates to the general US adult population



Note: * Denotes statistical difference from Medicaid at the p<0.05 level. "All" includes all coverage groups shown in the chart and groups not shown in the chart, including Medicare, military insurance, and individuals with other types of health coverage.

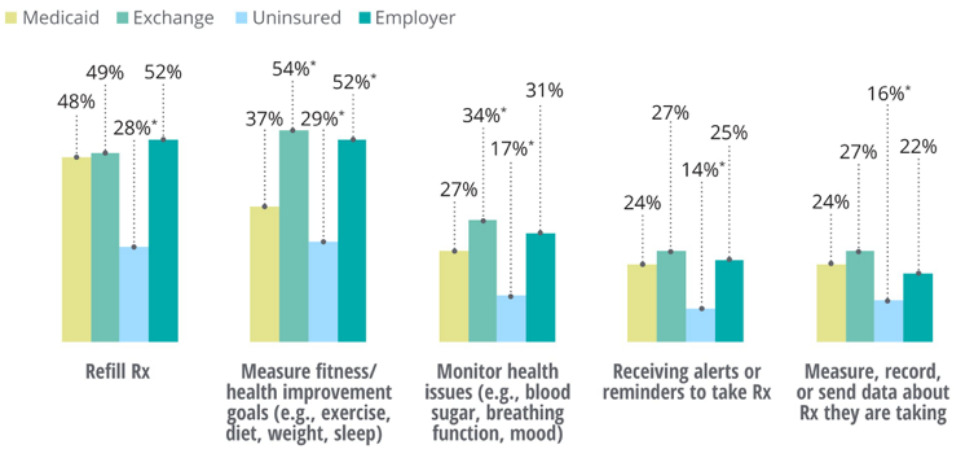
Source: Deloitte Center for Health Solutions' 2018 survey of health care consumers.

The rate of smartphone and tablet ownership among Medicaid beneficiaries increased by over 10 percentage points between 2016 and 2018

Note: * Denotes statistical difference from 2016 at the p<0.05 level. ^ Denotes a percentage point change.

Source: Deloitte Center for Health Solutions' 2018 survey of health care consumers.

Medicaid beneficiaries' use of technology for health purposes is generally similar to that of individuals with employer and exchange coverage, and significantly higher than those who are uninsured



Note: * Statistically different from Medicaid at the p<0.05 level. This question was asked to all respondents, including those who said they did not own mobile technologies.

Source: Deloitte Center for Health Solutions' 2018 survey of health care consumers.

Medicaid pays for roughly one-half of all births in the United States. MHealth and telehealth applications offer doctor-approved tips and health information, communication portals between patient and healthcare professional, vital information for doctor visits, and checklists. However, payment and cost barriers for these innovations can restrict use and applicability. This includes limiting ability to either identify for themselves or with the assistance of knowledgeable healthcare professional the nearest social services programs such as prenatal care, Women, Infants, and Children (WIC), well visit appointments, groups for new parents, grief and loss counseling, benefits, and insurance eligibility (e.g., redetermination reminders) meals, housing, transportation, Head Start, and home visiting.

Our Service and Population

The number of subsidized households in the suburbs of Chicago—from suburban Cook County to the surrounding counties of DuPage, Lake, Kane, McHenry and Will—rose nearly 30% from the year 2000 to 2015, according to the U.S. Department of Housing and Urban Development data and U.S. Census Bureau figures. Nearly half the suburbs' subsidized-housing units are in suburban Cook County. Of the 17 Cook County suburbs, 11 are in southern Cook County, which has experienced dramatic economic and racial upheavals because of the demolition of Chicago Housing Authority public housing as part of the Chicago Plan for Transformation beginning in the year 2000. The narrative persists in Harvey, Illinois where there is a food desert, poor economic development, a pharmacy desert, a shortage of maternal care, and studies that reflect access to physicians at a ratio of 3000:1 in South Suburban Cook County. This represents a vast difference

from the affluence of the northwest suburbs of Chicago where big box stores, fresh grocers, and satellite healthcare sites populate sprawling communities.

Dr. Lisa Green, the Co-Founder and CEO of Family Christian Health Center, a federally qualified health center located in Harvey, Illinois, has witnessed first-hand the migration pattern of the Southland communities since the year 2000 when the health center was founded. The problems that existed 20 years ago have been exacerbated by the demolition of Chicago's public housing. In February 2020, Dr. Lisa Green, along with a group of Black women physicians and nonprofit leaders began addressing health disparities and unique challenges of the birthing population on the South Side of Chicago and South Suburban Cook County; amid an alarming trend of hospitals discontinuing inpatient obstetric services and an unprecedented global pandemic. Family Christian Health Center (FCHC) is located within Illinois Hospital Planning Area A-04 but has patients that also span across Illinois Hospital Planning Area A-03, as it services nearly 20,000 patients across 57 zip codes. Since 2019, residents living in both hospital planning areas have experienced the discontinuation of labor and delivery services in four hospitals impacting over 300,000 reproductive age persons residing in those regions. For the city of Harvey, there are no perinatologists or neonatologists. High-risk pregnant patients must travel between 10 to 24 miles to receive advanced maternal care or neonatal care for infants.

In February of 2021, FCHC launched a 5,200 square foot standalone Maternal Child Health and Wellness center, located at 15620 S. Wood Street in Harvey, Illinois—as a repurposed health clinic owned by UChicago Medicine-Ingalls Memorial Hospital. The new health center marked an expansion of the Family Christian Health Center obstetrics and pediatrics program located at the main site (31 W. 155th Street, Harvey, IL) which has historically served nearly 20,000 patients per year across 57 zip codes throughout South Suburban Cook County, Will County and the metropolitan Chicago area. The facility contains 11 OB/GYN and pediatric exam rooms, eight office spaces, three clinical EHR spaces, a reception area, discharge and outreach areas, an employee lounge, pharmacy/storage room and Centering Pregnancy space.

Maternal mortality, much like infant mortality, is monitored worldwide as an indicator that reflects broadly on the health of a society, as stated by the Illinois Department of Public Health. The American College of Obstetricians and Gynecologists note that of the 700 pregnancy-related deaths that occur each year in the U.S., one-third happen one week to one year after pregnancy; beyond these deaths, every year about 50,000 women experience a severe health issue as an outcome of labor and delivery. In 2017, a total of 103 women died while pregnant or within one year of pregnancy—considered the highest number recorded to date, according to the 2021 IL Maternal Morbidity and Mortality Report. In fact, maternal mortality and severe maternal morbidity rates in Illinois represent some of the highest in the nation. Women with Medicaid

coverage at delivery were five times more likely to die from a pregnancy-related cause than women with private insurance.

Medicaid plays a significant role in providing maternity care, including the number of births covered by Medicaid. However, given the percentage of birthing persons and infants it services, and the detrimental societal effects of poor maternal and birth outcomes, less attention has been paid to the role of Medicaid in mitigating these adverse health outcomes.

Governance Structure

Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated, and priorities set? Accountability. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence? Payments and Administration of Funds. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose?

Family Christian Health Center will serve as the lead recipient and lead organization coordinating hiring, training, billing, legal fees, accounting, and reporting. No new entities are being formed.

At the time of submission, MCHWCTC partners have agreed to come together for the purposes of this proposal ad described herein. We are working on MOUs to bind ourselves legally together for that endeavor, while we continue to discuss the specifics of how the program must be structured in order to ensure success, mitigate risk and ensure trust is established among partners that transcends the collaboration and positively impacts the patient experience.

MCHWCTC will comply with all regulations around governance required by HFS and all other applicable agencies, specifically to execute a binding contractual agreement among all parties to supplement existing agreements among specific entities within the collaboration. This will be completed at a moment TBD in the future, post-award, but before payments commence. The HFS Guide to TC Collaborations Document will be fully followed to steer development of the build-out and agreements, addressed in the appropriate timeline.

Key Governance Activities to occur in months 1-3 of Year 1:

- Finalize MOUs
- Formalize strategic outlays and responsibilities
- Ensure distribution of funds, communication of accounting and reporting standards
- Announce Program to practitioners, clinical partners, MCOs, and the public
- Send invitations to participate in the Community Advisory Board
- Prepare for hiring and training

- Hire and onboard project lead managers

Governance Outline

A Community Advisory Board (CAB) will be formed in collaboration with Black Girls Break Bread, a minority- and woman-led 501(c)(3) nonprofit organization. It will be onboarded within the first year of work to adequately incorporate community feedback into building our structures and policy and developing the technology tool. The CAB will act as an essential participant in the governance of MCHWCTC.

Racial Equity

The effects of racial inequities in South Side Chicago and South Suburban Cook County are decades old. The inequities encompass educational opportunities, accessible healthy food, home ownership, and access to jobs that pay a living wage, affordable childcare options, and disinvestment in healthcare facilities and pharmacies. The system of neighborhood investment, shaped by redlining, affects businesses and food choices presented to the residents of those neighborhoods. If you're Black or Latino in Chicago, you're less than half as likely to have access to healthy foods, you're more likely to live a shorter life as a result, and though you may want to change the options available to your community, you're less likely to obtain a loan to start your own business.

Racial inequities in healthcare don't just disproportionately impact women and infants, they affect generations of families and the communities in which they live. For example, "Latino Chicagoans are more than twice as likely to be uninsured than their white counterparts. A lack of incentives for clinics and pharmacies to open in majority-Latino or majority-Black neighborhoods means that getting medicine or treatment can be a very different process, depending on where you live. This has resulted in a loss of years of life. Black Chicagoans have more than twice the number of preventable hospitalizations as white Chicagoans and die almost 10 years sooner[2]." Finally, communities that lose hospitals, lose doctors, too.

Further, the racial wealth gap determines who has access to the best healthcare. Hospitals in low-income communities are commonly the last to receive state-of-the-art equipment. Likewise, racism shows up in doctors' offices. Nearly half of medical students surveyed believed that Black people have thicker skin, faster-coagulating blood, and/or less sensitive nerve endings than white

[2] Husain, N., Rockett, D., Johnson, C. and Brinson, J., "Disinvestment in Black and Latino Chicago neighborhoods is rooted in policy." *Chicago Tribune,* July 2020.

people, according to a 2016 study in the Proceedings of the National Academies of Science. Trainees who believed that Black people were less sensitive to pain were less likely to treat the pain adequately[3].

Racial Equity Impact Assessment Questions

1. Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?

The racial/ethnic composition of the FCHC service area is 62% African American, 13% Hispanic and 23% non-Hispanic white. Approximately 21% of residents in the service area are impacted by poverty, living 200% below the federal poverty level. The lack of access to healthy food across the FCHC service area leaves more than 360,000 people living with food insecurity. Today, these communities continue to suffer among the worst health outcomes in the state. The lack of local health care in the 57 zip codes FCHC serves, spanning portions of Cook and Will counties in Illinois and Lake County Indiana, leaves some patients traveling 40 miles or more than an hour to receive health services.

According to the Illinois Department of Public Health, between 2008-2016, more than 600 women died within a year of pregnancy; an average of 73 women died each year. While shocking, the racial disparities in maternal mortality for Black women across the state are profound. Black women in Illinois are six times more likely to die of a pregnancy-related condition than their non-Hispanic White counterparts.

2. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?

Within the Maternal Child Health service area where 56% are women and 30% are children; 78% identify as African American, 16% Latino, 4% Asian and 2% White. Discussions with a group of practicing Black women physicians and community-based nonprofit leaders, all practicing and engaged in community on the South Side of Chicago and South Suburban Cook County indicated a dire need for increased access to wrap-around services and advanced maternal care. Further the patient population and external stakeholders in the community were involved in the development through community forums over the last 18 months, via email listserv and internal communications.

[3] (Brandt, Katie S., The Great Unequalizer, https://chicagohealthonline.com/the-great-unequalizer/, accessed November 17, 2021)

3. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

Chicago's South Suburbs face a nexus of challenges across care delivery and health outcomes. A history of inequity and disinvestment has culminated in poverty rates of more than 60% in some neighborhoods and population loss of one in five residents in the past thirty years. This has both caused and been compounded by insufficient, inadequate, and declining medical services: there is an estimated shortage of approximately 100 primary care providers and 60 OB providers. The CMS star rating for most hospitals on the South Side falls below the national average; and there has been more than a dozen inpatient service or hospital closures in the past ten years—all contributing a 50%-plus rate of South Side and South Suburban residents leaving their community for care. Paradoxically, this dearth of care has partly contributed to overutilization as high as 60% in expensive emergency and inpatient settings, even as local hospitals continue to see occupancy of less than 60% due to out-migration. The result of these care delivery challenges is a staggering disparity in health outcomes: compared to North Side residents, South Siders in some neighborhoods have a 30-year lower life expectancy, are at a ten times higher risk of infant mortality and have four times the rate of deaths from diabetes. These tolls have been further exacerbated by the COVID-19 pandemic, as evidenced in the highly disparate unemployment and death rates relative to white residents and North Side neighborhoods. There is no silver bullet to address these issues; they require a solution that is both comprehensive and transformative.

4. What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

A 2018 article in *The Atlantic* notes "the legacy of segregation has made it difficult for poor black families to gain access to economic activity in other parts of the city. This segregation has meant that African Americans live near worse educational opportunities and fewer jobs than other people in Chicago." This issue continues to have an impact on residents in the south suburbs, particularly people of color. Further exacerbating the problem is the loss of industry in the area. With the closure of local steel mills, factories, and manufacturing businesses came the loss of jobs and access to jobs, leading to the loss of money spent on local businesses in the area. The absence of job opportunities often leads to a rise in violence which in causes more businesses to leave the community. The closure of these businesses resulted in a deficiency of resources locally. Lack of education, lack of jobs, and lack of resources create an indelible cycle of poverty.

Racial disparities in healthcare continue to be widespread in south suburban communities. The FCHC service area faces significant challenges and bears an unnecessary burden of excessive social, economic and health inequities including high rates of poverty, unemployment, substance abuse, morbidity, and mortality due to chronic and infectious diseases in addition to insufficient

access to transportation healthy foods and quality healthcare. Generations of structural inequality and lack of opportunities have contributed to the erosion of the necessary social, economic and health advantages necessary to promote the healthy infrastructures required to adequately address the health needs of the communities served. In the area served, 33% to 50% of people suffer from food insecurity, more than double the statewide rate of 13.6%.

Despite attention to these disparities in the south suburban communities over the last decade, there has been limited progress in reducing racial disparities. To make inroads into addressing racial disparities in the communities it serves, as described throughout this proposal, FCHC is committed to racial equity to achieve our mission. FCHC is moving beyond care delivery as obligated solely in a clinical relationship and instead, incorporating an understanding and supports to address many of these racial equity health determinates.

5. What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

This project seeks to create opportunities for residents in the Chicago Southland region to obtain access to quality healthcare and to create opportunities to dramatically reduce the incidence of maternal mortality. Additionally, it will create healthy life patterns and habits among the beneficiaries, leading to increased life expectancy, lower infant mortality, better parenting skills, and increased access to other social services and resources.

6. What are negative or unforeseen consequences and positive impacts/opportunities for equity because of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized?

This project will have a positive impact on and increase opportunities for equity for residents of South Suburban Chicago, particularly economically disadvantaged populations through increased access to care and the creation of jobs.

7. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

Family Christian Health Center's model of care includes a whole person approach that includes not only healthcare but mental and spiritual care. FCHC staff take pride in their ability to recognize when their patients are in crisis and help provide a bridge to care. By offering access to free food, referrals to housing and services, the positive impact reaches beyond the realm of healthcare. The implementation of this project will create job opportunities for people in the community and create increased economic development in the service area. The shared values of racial equity and inclusion are imbedded in the framework of Family Christian Health Center and the organization is always looking for opportunities to engage in the creation of social change.

8. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

Family Christian Health Center opened its Maternal + Child Health Center in 2021 and has effectively seen a growing number of patients.

9. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

Indicators of success and progress benchmarks will include higher numbers of healthy pregnancies and childbirth in the service area and increased participation in our Centering and other prenatal and postnatal programs.

Impacts will be documented by recording patient diversity information and outcomes and using patient surveys.

Community Input

Service Area of the Proposed Intervention. Identify your service area in general terms. Please list all zip codes in your service area, separated by commas. Describe the process you have followed to seek input from your community and what community needs it highlighted.

Community Service Area

The FCHC Maternal and Child Wellness and Health Transformational Collaborative is focused on the existing OB/GYN service area encompassing 29 zip codes and the following neighborhoods on Chicago's South Side and South Suburban Cook County: Alsip, Beverly, Blue Island, Burnham, Calumet City, Calumet Heights, Chatham, Chicago Heights, Country Club Hills, Crestwood, Crete, Dixmoor, Dolton, East Hazel Crest, Flossmoor, Ford Heights, Glenwood, Harvey, Hazel Crest, Lansing, Lynwood, Markham, Matteson, Midlothian, Morgan Park, Oak Forest, Park Forest, Phoenix, Posen, Pullman, Richton Park, Riverdale, Roseland, Sauk Village, South Chicago, South Deering, Tinley Park, University Park, and West Pullman..

South Side Chicago Zip Codes				
60617	60619	60628	60633	60643
South Suburban Cook County Zip Codes				
60406	60409	60411	60417	60419
60422	60425	60426	60428	60429
60430	60438	60443	60445	60452
60466	60469	60471	60472	60473
60477	60478	60484	60827	

Within the service area where 56% are women and 30% are children; 78% identify as African American, 16% Latino, 4% Asian and 2% White. 70% of the patient population are insured by Medicaid, 20% have private insurance, 6% insured by Medicare and 4% are self-pay.

Direct Community Input

Discussions with a group of practicing Black women physicians and community-based nonprofit leaders, all practicing and engaged in community on the South Side of Chicago and South Suburban Cook County indicated a dire need for increased access to wrap-around services and advanced maternal care. The following healthcare providers were engaged:

- Dr. Shelley Amuh, OB/GYN
- Dr. Joy West, OB/GYNDr. Jamie Horn, OB/GYN
- Dr. Catherine Harth, OB/GYN
- Dr. Robin L. Jones, OB/GYN

In November of 2019, Dr. Lisa Green, along with a group of Black women physicians and nonprofit leaders, formed the SOS Collaborative to address health disparities and unique challenges of the birthing population on the South Side of Chicago and South Suburban Cook County. The collaborative comprises Chicagoland-based practicing physicians ranging from obstetrics and gynecology, internal and family medicine, and leaders of a community based nonprofit organization, Black Girls Break Bread.

In February of 2020, the first formal convening was held as a state-wide forum at South Suburban College where nearly 100 stakeholders in medicine, public health, community-based organizations, Illinois residents, managed care organizations, researchers, and health systems, gathered for a half-day conference on the State of Black Maternal Health ending with a breakout session for attendees to engage in solution-driven documented discussions. The primary topics of the conference detailed the lack of Maternal-Fetal Medicine access in the Southland community, transportation barriers for patients, and Medicaid network challenges. Panelists and speakers included the chair of the IL Maternal Mortality Review Committee, OB/GYNs from federally qualified health centers, Advocate Health Care, Rush University Medical Center and UChicago Medicine - Ingalls Memorial, Maternal-Fetal Medicine specialists from UChicago Medicine - Hyde Park and the CEO of the Illinois Association of Medicaid Health Plans.

Amid an alarming trend of hospitals discontinuing inpatient obstetric services at the onset of an unprecedented global pandemic, the SOS Collaborative transitioned the convenings beginning in April of 2020, to a virtual format via Facebook Live, hosting local and national panels with hospital administrators and OB/GYN physicians and residents to raise awareness around the gaps in care further exacerbated by COVID-19. From direct accounts of OB/GYNs within the SOS Collaborative,

there were numerous instances of pregnant patients being uncertain of where to go for labor and delivery on the South Side of Chicago, no access to Electronic Health Records when pregnant patients arrived at the emergency room, and telehealth not being a viable option for pregnant patients due to no access to blood pressure cuffs. In June 2020, one community hospital ended the suspension of the labor and delivery unit, and the Department of Healthcare and Family Services issued an announcement that allowed pregnant Medicaid customers to receive a free blood pressure cuff with a physician's prescription.

During this process, many stakeholders were championing the efforts of the SOS Collaborative and urging for impactful interventions. Black Girls Break Bread was invited to sit on local, state, and federal Maternal and Infant Health task forces and in October 2020, Family Christian Health Center announced plans to open a dedicated Maternal and Child Health and Wellness Center within walking distance of the main Harvey, IL site to be located on the UChicago Medicine-Ingalls Memorial Hospital Campus.

In January 2021, members of the SOS Collaborative presented as public speakers during a Medicaid Advisory Committee meeting to provide a solution-oriented approach to the gaps in maternal care access experienced by its patients on the South Side of Chicago and South Suburban Cook County.

The Family Christian Health Center - Maternal Child Health and Wellness location successfully opened in February 2021 as a dedicated health center for obstetrics, gynecological and pediatric care with an official grand opening in April 2021—garnering media attention and support of legislators.

In June 2021, the SOS Collaborative hosted a virtual national conversation with federally qualified health center CEOs, OB/GYNs and technology architects on the role of FQHCs in mitigating maternal morbidity and mortality. Additionally, a stakeholder email listserv was amassed through which updates and communications were disseminated, viewership of virtual convenings exceeded 3,000 and the SOS.

Data Support

Describe the data used to design your proposal and the methodology of collection. Attach the results of the data analyses used to design the project and any other relevant documentation.

The data informing our proposal is derived from our internal patient records and HRSA Uniform Data System (UDS) reports. This proposal seeks to strengthen data and surveillance for expectant mothers and families, closing significant data and technology gaps. Family Christian Health Center (FCHC) is located within Illinois Hospital Planning Area A-04 but has patients that also span across Illinois Hospital Planning Area A-03, as it services nearly 20,000 patients across 59 zip codes. Since 2019, residents living in both hospital planning areas have experienced the discontinuation of labor and delivery services in four hospitals impacting over 300,000 reproductive age persons residing in those regions. For example, for the city of Harvey there are no perinatologists or neonatologists. High-risk pregnant patients must travel between 10 to 24 miles to receive advanced maternal care or neonatal care for infants. Today, the Maternal Child and Wellness Center serves 8,500 expectant mothers and their families. Under this proposal FCHC is anticipating a 10%-15% direct patient service increase per year over the 5-year period. Expectant mothers and families served over the next five years (Year 1= 8,500; Year 2 = 9,775; Year 3 = 11,241; Year 4 = 12,900; Year 5 = 14,800).

Health disparities and health inequities are correlated with the dearth of timely, accurate and consistently reported data. This proposal helps gather are data on need, use, and resource availability for maternal/family grieving and loss, emergency and transitional housing needs, food insecurity need, use, and resource availability, and transportation need, use and resource availability. All these factors correlated with provider access and engagement, mobile health access and use and birth outcomes including emergency department use, late-term and low-birth weight risks and other preventable risk factors.

For example, shortages in maternity care can lead to inadequate care for pregnant patients, by contributing to fewer appointments, long wait times, and an increase in the average travel time required to obtain a prenatal care visit and or birthing site. Receiving adequate, early, and regular prenatal care improves early screening, detection, and treatment of postpartum mental health to impact the health and wellbeing of mothers and infants. Family Christian Health Maternal Child and Wellness Center mobile application, and extended staffing capacity will play a major role in ensuring real-time data collection on need, utilization, and resource availability. This collaborative takes a comprehensive population health approach to equitable access to maternal, child health and family-systems healthcare and provides mush needed data and surveillance that will strengthen the safety net for the most vulnerable communities.

Population Health Data Management and Data Sources.

Population health data management will be provided by Clinify Health, a minority-owned and operated entity. Clinify Health is poised to provide technology for lead HL7® Fast Healthcare Interoperability Resources (FHIR®) basics, vocabularies, and terminologies, and serve as a decision-making tool for public policy. Their capabilities include combining multiple data streams (e.g., clinical data from electronic health records, lab results, immunizations, demographic data, utilization metrics, claims data, and data from other non-healthcare sources such as SDOH, environment) for analytical and exchange purposes.

Clinify Health is a venture-backed healthcare technology company that works with healthcare providers and payers who work with patients living in medically underserved communities. Their mission is to enable stakeholders throughout the healthcare value chain to manage their patient populations more proactively in a manner that emphasizes preventive care delivery and a focus on primary care management of the most prevalent chronic conditions impacting minority, low-income, and disabled patients throughout the United States.

Clinify Health, for example, will serve as a technological and mobile health hub for increased utilization and access to medical devices, telehealth, and health care professionals to address disparities. Clinify Health is an innovative solution for elevating a technological repository for better population health and community profiles, bridging federal and local policies (e.g., Medicaid) and public health solutions addressing social determinants of health.

Clinify bridges this gap by integrating our data and analytics staff with our clinical strategists, thereby providing a comprehensive view of the public health ecosystem. Clinify Health digital health technology solution, called CareTrax® is used in operation by clinics across the United States to manage more than 150,000 patients, providing analytic insights on their care needs based on medical and social data points.

Other Data

In addition to the HRS UDS data, this collaborative will draw from and analyze Medicaid Statistical Information System (MSIS), the Medicaid Analytic eXtract (MAX) files, and the CMS-64 reports data. MSIS is the basic source of state-submitted eligibility and claims data on the Medicaid population, their characteristics, utilization, and payments.

The Medicaid Analytic eXtract (MAX) data–formerly known as State Medicaid Research Files (SMRFs) – are a set of person-level data files derived from MSIS data on Medicaid eligibility, service utilization and payments. These data are developed to support research and policy analysis initiatives for Medicaid and other low-income populations.

Our collaborative aims to use these and our internal patient data to measure impact in terms of birth outcomes, reimbursements, and utilization. Together this data will be essential to modeling not only better care, but also for sustainability and advanced payment methodologies.

Health Equity and Outcomes

Name the specific healthcare disparities you are targeting in your service area included by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes. What activities will your collaboration undertake to address the disparities mentioned above? What immediate measurable impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting? What will the activities you propose lead to the impact you intend to have?

'The disparity between Black and white maternal death rates in the new (IL Maternal Mortality) report was about half what it was in the state's first report, which analyzed mortality rates in 2015. But Dr. Ezike said the gap was not closed by progress for Black Illinoisans. "In our first report we indicated that Black women were more than six times as likely to die from a pregnancy-related condition as white women," Ngozi said during the presentation. "It is not due to conditions improving for Black women, but it's instead due to worsening conditions for white women, especially due to mental health conditions, including substance use disorder and suicide."'

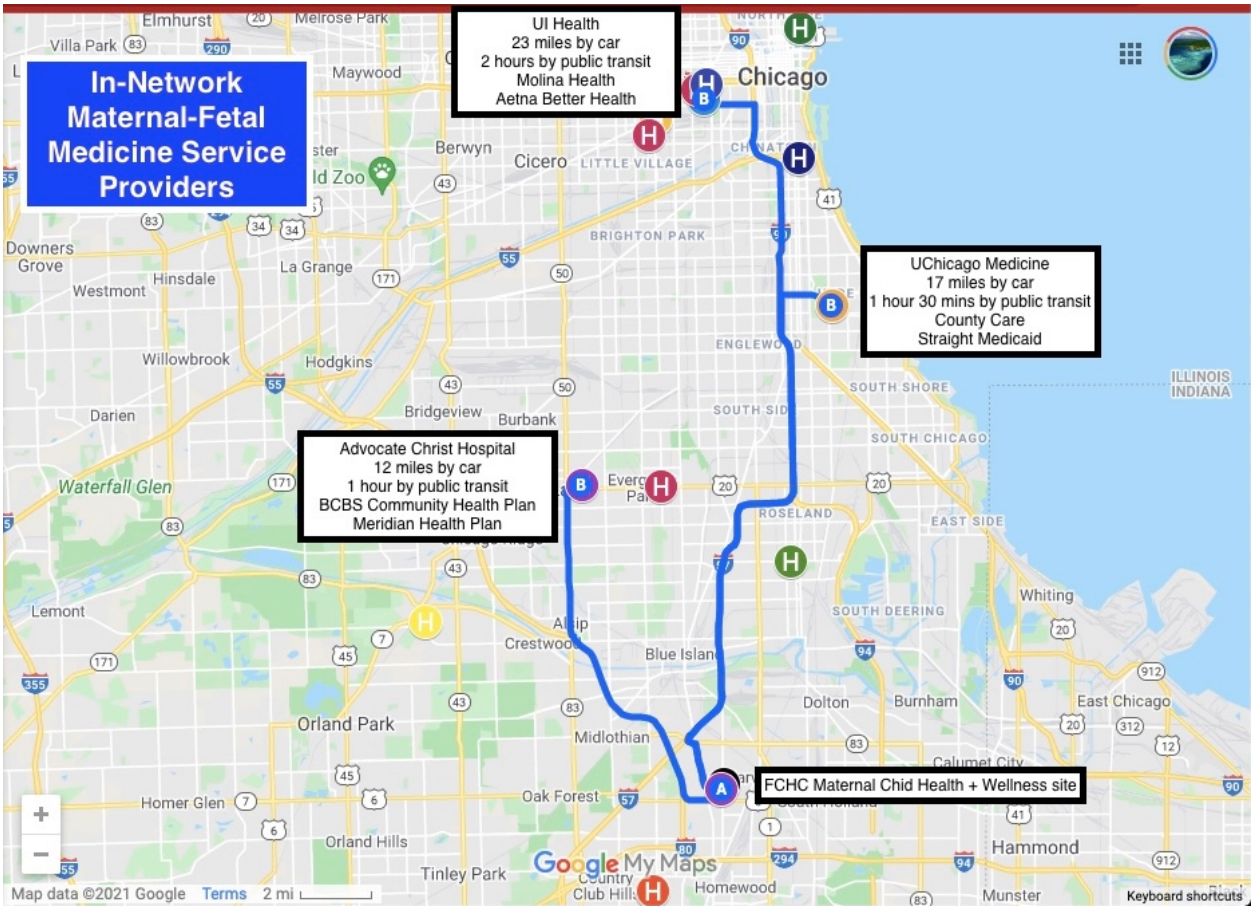
As reported in the 2021 Illinois Department of Public Health Maternal Morbidity and Mortality Report, the three most common causes of pregnancy-related deaths were pre-existing medical conditions, hemorrhage, and hypertension disorder; responsible for 46 percent of deaths in Black residents and 33 percent of deaths in Hispanic residents. All hemorrhage deaths recorded happened to Black women. Women who were on Medicaid were most likely to have a death occur during pregnancy, childbirth and postpartum.

Access to high-quality, affordable obstetrics, gynecological and pediatric care will not only benefit residents within the Southland communities but also the far south side of Chicago, all of whom are living within maternal-care deserts. The void left with the closures of hospitals and suspension of inpatient obstetric services on the South Side of Chicago and South Suburban Cook County (IL Hospital Planning Areas A-03 and A-04) including Jackson Park Hospital, Holy Cross Hospital, St. Bernard Hospital and Metro South Hospital has drastically limited access to birthing hospitals, specialty care, ultrasounds, and ancillary services.

Access to Care

Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes. What activities will your collaboration undertake to address the disparities mentioned above? What immediate measurable, impacts will follow from these activities that will show progress against these obstacles or barriers you are targeting? What will the activities you propose lead to the impact you intend to have?

FCHC Maternal and Child Wellness Collaborative is poised to substantially increase and enhance access to primary and advanced maternal care. This transformative healthcare model addresses current gaps in proximate access to high-risk obstetric care as well as barriers with network insurance eligibility and transportation.



Communities with a history of disinvestment deserve dedicated and proximate resources to research, diagnosis, treatment, and prevention. Navigating healthcare as a woman can be complex as it is very fragmented, compounded with structural barriers that can be virtually insurmountable for many with limited resources. Family Christian Health Center - Maternal Child Health and Wellness site plans to provide a central location of multidisciplinary tertiary

integrated care service for high-risk pregnancies and optimize pre-pregnancy care and counseling for prospective mothers with risk factors.

Family Christian Health Center has a long-standing relationship in the Southland community for caring for pregnant patients, in particular high-risk pregnancies and those with comorbidities and complications. Partnering with the Maternal-Fetal Medicine team of a tertiary teaching hospital and academic medical center will allow the establishment of a multi-disciplinary comprehensive clinic within a community that currently does not have access to perinatologists. The intention is to optimize and streamline the coordination and operation of these services together with other prenatal services under one center.

Family Christian Health Center will also work very closely with the UChicago Medicine Neonatology department, whose expertise is in intensive and critical care for infants to ensure the best possible outcomes in high-risk pregnancies. Being aware that the mental health of a birthing person is very important to their overall health and wellbeing, Family Christian Health Center will expand the number of mental health professionals with the Maternal Child Health + Wellness Center including psychiatrists, social workers, and counselors.

Current obstacles to healthcare include transportation, housing, and childcare. Although Illinois Medicaid and MCOs offer transportation services for no charge, patients must request service three business days in advance. When patients need same-day appointments or get access to a next-day appointments with both FCHC and high-risk offices, they don't have the option to utilize the service provided by their insurance. This puts limitations on access to care and pushes back the appointment dates.

Currently in the south suburbs, emergency housing has changed course due to the Covid-19 pandemic. The emergency shelter system is no longer a walk-in option and patients must call to be put on a waiting list. To keep the public safe, the shelter model transitioned to a hotel shelter model, which limits the amount of people they can offer services for at a given time. This limits local services for patients in the south suburban cook county area. Often, our team must refer to other options in the City of Chicago, in which many patients may not have transportation to nor are familiar with the area. This creates a huge barrier to housing and emergency shelter.

Childcare continues to be a concern for our patient population. For families who do not utilize childcare services frequently and need to have diagnostic testing, they often have limitations due to not having family or friends to watch over their children for that day/few hours. We refer to our partnered organizations, however, there is a process that does not get approved overnight. This creates gaps of care for services.

Activities include additional care coordination from the additional staff. Each OB patient will be assessed during each trimester to ensure we provide support, access, and follow-up. We need

additional staff to provide surveillance over the number of patients that are in all phases of their pregnancy. Each month more patients are added to the case load and continue to cycle monthly, as new OB patients come in. We need the support to monitor a patient's care throughout their entire pregnancy and not just after intake, as needed and post-partum. The additional staff will also assist with the warm hand-off from OB to Pediatric care. Currently our one Case Manager is managing both mom at post-partum and newborn care. This then addresses mortality and morbidity rates among our patients.

Housing will provide access to care and social support. This impact will provide equal distribution of resources and opportunities to our patients. This initiative will impact a patient's mental health status and elevate the stress they have that can impact their pregnancy outcomes.

Current measures for success include follow-up on the services and resources provided. When a family identifies as homeless and our Case Manager coordinates housing and the family indeed obtains the service, this is a success. We do not have the capacity to generate reports from the EMR system based on services/resources. Currently we can extract data for touchpoints/interactions within patient charts by Case Manager.

Immediate measurables include less gaps of care, more monitoring/surveillance for each OB patient at multiple times during their pregnancy and response times will be impacted positively with more interventions.

Impact includes overall wellness for mom and baby. The trust created by the Case Managers leads the patients to communicate freely on their current lifestyles and needs. The more monitoring of this population creates more follow through regarding their healthcare and social needs. We want our moms and families safe, housed, and given resources for social reasons to impact their social needs to focus on their health care needs.

Social Determinants of Health

Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes. What activities will your collaborative undertake to address these disparities mentioned above? What immediate measurable, impacts will follow from these activities that will show progress against the obstacles you are targeting? What will the activities you propose lead to the impact you intend to have?

Social determinants of health (SDOH), defined as the conditions in which people are born, grow, work, learn, play, worship, and age, profoundly influence health outcomes. SDOH are largely driven by institutionalized and structural racism, economic factors, and the unequal distribution of power. Common individual-level needs that result from SDOH are often referred to as health-related social needs. There is a growing consensus among medical providers and medical systems that they can play an essential role in addressing these nonmedical, social needs to improve

population health and reduce the costs of care. In recent years, numerous studies have demonstrated that practice- and hospital-led interventions that screen for and address patients' social needs—either through referrals to an outside service agency or through integrated programs—can lead to improved health outcomes and reduce the cost of care.

Our Healthcare Transformation Collaboratives work will screen for and implement intervention mechanisms to address the following three social needs:

- **Food insecurity**. Food insecurity is defined as limited or unreliable access to enough affordable, nutritious food. Food insecurity has health consequences across the life course, and is particularly relevant for pregnant and postpartum women, given that food insecurity can affect dietary intake, contribute to depression and anxiety, and impact young children's developmental trajectories. There is growing evidence that health facility-based prescription program for fresh produce and other healthy foods can increase the purchasing and consumption of nutritious foods among food-insecure households.

- **Housing instability**. Individuals and households suffer from housing instability if they live in unsafe or unhealthy housing conditions, experience frequent housing disruptions, homelessness, and/or are unable to make monthly rent or mortgage payments. Housing impacts health through several pathways, including environmental exposures (e.g., mold, inadequate heating), psychosocial stress, and neighborhood factors (e.g., safety). Several studies evaluating housing interventions in the clinical setting such as housing modifications and housing mobility interventions have demonstrated positive effects on health outcomes such as diabetes and asthma, as well as reduced healthcare spending.

- **Transportation barriers**. Difficulties accessing or affording transportation impact patients' health by causing missed or rescheduled appointments and delayed care. Transportation barriers are most pronounced among patients who are female and non-White and are particularly relevant in the context of prenatal care, as missed appointments may prevent timely risk assessment and lead to pregnancy complications. Evidence is building that transportation interventions can significantly decrease no-show rates and increase patient satisfaction.

FCHC Maternal and Child Wellness Collaborative will integrate the Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool into the intake process for a patient's initial prenatal care visit. This tool was developed by the Centers for Medicare and Medicaid services through collaboration with a panel of experts in SDOH and may be used among a variety of patient ages and backgrounds. Current intake procedures for prenatal care patients at FCHC include the administration of a Barriers Assessment Tool by OB/GYN and pediatric case manager. In the future, we will add to this tool five questions from the AHC Screening Tool that

pertain to the three prioritized SDOH domains: food insecurity, housing instability, and transportation.

Since the AHC Screening Tool has only one question about transportation, we will also assess potential transportation difficulties with the question, "Will you have adequate transportation to help you keep your prenatal appointments?" In addition, the expanded Barriers Assessment Tool includes the following questions:

- Background characteristics
    - Is this your first pregnancy?
    - Are you 18 years old or younger?
    - Do you have support from family or friends?
- Pregnancy attitudes and goals
    - Are you having mixed feelings about this pregnancy?
    - What are your goals for this pregnancy?
    - What could be a challenge during this pregnancy?
    - What are your concerns?
- Interest in assistance
    - Are you interested in assistance related to food, housing, and/or transportation?
    - Are you interested in any additional supportive services related to pregnancy (e.g., prenatal classes, breastfeeding classes)?
- Have you been abused within the last 12 months?
- Is there anyone or anything that makes you feel unsafe?

Given that the AHC Screening Tool questions are short and streamlined, we are confident that they can be easily incorporated into FCHC's existing clinical workflows, especially with the addition of new case management staff. Case managers will be provided with in-depth training in the relevance of screening, the efficient delivery of screening questions, and communication skills to increase patients' comfort level. Specifically, case managers will be trained and supported to use a patient-centered approach drawing on the Oregon Primary Care Association's "empathic inquiry" model. This includes principles such as respecting patients' autonomy and privacy, providing a clear explanation for the screening and how the information will be used, being non-judgmental, and approaching the social needs screening as a partnership.

Table 1: AHC Health-Related Social Needs Screening Questions:

Social Needs Domain	AHC Questions	Response options*
Housing instability	What is your living situation today?	I have a steady place to live
		I have a place to live today, but I am worried about losing it in the future
		I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
	Think about the place that you live. Do you have problems with any of the following? [Choose all that apply]	*Pests such as bugs, ants, or mice*
		Mold
		Lead paint or pipes
		Lack of heat
		Oven or stove not working
		Smoke detectors missing or not working
		Water leaks
		None of the above
Food insecurity	Within the past 12 months, you worried that your food would run out before you got money to buy more.	*Often true*
		Sometimes true
		Never true
	Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	*Often true*
		Sometimes true
		Never true
Transportation	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	*Yes*
		No

*If the patient chooses the italicized response options, they may have an unmet health-related social need.

The identification of patients' health-related social needs through this screening process will enable FCHC staff to address and alleviate these needs through innovative programming and referrals to community partners. To address food insecurity, **FCHC Maternal and Child Wellness Collaborative** will implement a "prescription" program for healthy food and beverages that will be delivered on-site RxMeals). For pregnant patients who screen positive for food insecurity during the intake process, case management staff will immediately send a notification to the attending physician. At the end of the prenatal care visit, the physician will provide the patient with a prescription card for healthful eating accompanied by coupons for fresh produce and other healthy foods that can be redeemed at the on-site food pantry. In addition to this new program, food-insecure patients will also be assisted by the case management team with direct referrals to local WIC (Women, Infants, and Children) offices through FCHC's partnership with the Community and Economic Development Association of Cook County, Inc. (CEDA). There are three CEDA WIC offices in FCHC's catchment area.

Addressing Housing Instability

To assist patients who screen positive for housing instability, **FCHC Maternal and Child Wellness Collaborative** will establish a dedicated mother-and-child emergency and transitional housing referral services. These services will be available to patients who are experiencing housing insecurity, homelessness, or unstable living conditions and who meet the qualification criteria. FCHC is collaborating with Community Christian Health Center in Chicago. FCHC Maternal Child Health and Wellness Collaborative will provide stipends for up to 90 days to support costs associated with emergency and transitional placement. Qualifying patients may apply or be considered for an additional 90 days. While in emergency and transitional housing, patients will work with a dedicated housing liaison to find and secure permanent housing. Alongside this program, case managers will also be poised to provide patients with direct referrals to community agencies offering housing assistance, mortgage assistance groups, and homeless shelters.

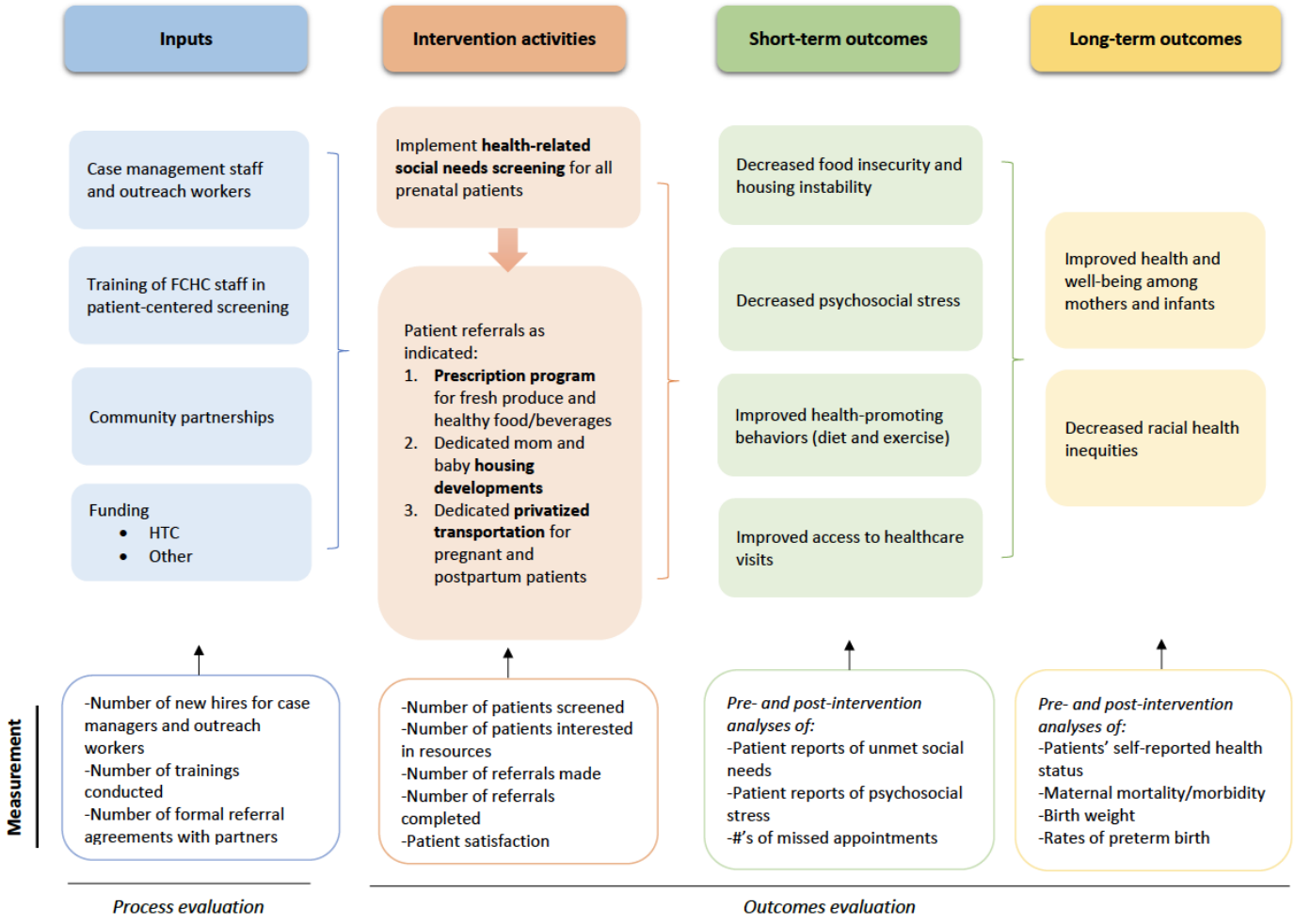
For patients who face transportation barriers, case managers will connect them with a privatized transportation service dedicated to pregnant and postpartum patients. In addition to offering this service to patients who screen positive for transportation difficulties on the Screening Tool, case managers will also contact patients who have two no-show appointments during the prenatal period, to ensure that patients do not fall through the cracks.

Information about a patient's identified social needs and referrals will be documented in structured fields in the patient's chart. This will include recording the patients' responses to the Screening Tool, and information about referrals made and referrals completed. This documentation process will facilitate patient follow-up and will also enable an evaluation of the program's reach.

The logic model displayed below traces the links between the inputs, the screening and referral activities, and maternal and infant health outcomes. Specifically, the screening and referral activities will be made possible through inputs including increased numbers of dedicated case managers and outreach workers, training sessions underscoring patient-centeredness, a large network of community partners, and funding resources. We anticipate that the prescription food program, housing development program, and other referrals for food and housing needs will result in the short-term outcomes of decreased rates of unmet social needs and improved health-promoting behaviors like diet and exercise. The dedicated transportation service will lead to improved access to healthcare visits and lower rates of missed or rescheduled appointments.

At the same time, these intervention activities will together reduce the burden of psychosocial stress in patients. Ultimately, we anticipate that these short-term outcomes will lead to general improvements in maternal and infant health outcomes and a reduction in racial health inequities.

Figure 3: Logic Model



Care Integration and Coordination

Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care. Do you plan to hire community health workers or care coordinators as part of your intervention? Are there any managed care organizations in your collaborative?

Currently the Care Coordination Team at MCHC consists of one full-time Case Manager and one part-time Case Manager. Both are responsible for identifying barriers to care and aids obtain services to close care gaps. Upon intake, which each OB patient is given as their initial OB visit, the patient completes our barrier intervention called the Prenatal Service Barrier Assessment. This assessment is conducted by the Provider in person with the patient to better understand our patients' needs and lifestyle. Part of the PBSA, goals are created and reviewed by the provider to build a relationship and initiate trust initiatives between patient and the provider. Within 24 to 48 hours after the OB Intake, the full-time OB/PEDS Case Manager will reach out to the patient to review the PSBA and provide additional supportive services if the patient screens positive for any questions asked. If the CM identifies that the patient is not currently in need of services, the CM will ensure the following:

a) They understand the purpose of the Case Manager
b) Patient has insurance
c) Patient is aware of their insurance Maternity programs/benefits
d) Patient has the case manager's direct phone number for future assistance
e) Patient is given transportation options from Illinois Medicaid/MCOs.

The PSBA addresses social determinants of health including family support, housing, transportation, domestic violence, food, clothing, employment, and parenting resources. In addition to reviewing the PSBA with the patient, our Case Manager reviews all referrals to Behavioral Health due to screening positive for their depression screening. The Case Manager will follow-up with patients, provide education on the referral, inquire status, assist in scheduling and follow-up to ensure patient completed appointments. Next, case management referrals can be generated from OB providers when they identify the need for additional supportive needs during Prenatal Care visits after the patient's initial screening with the Case Manager. This allows the Case Manager to follow-up again to assess needs during their current stage of pregnancy. After the referral is routed to the Case Manager, they have 24 to 48 hours to follow-up and assess. However, if patients are unsafe or homeless, the Case Manager assists immediately.

All interactions with our Case Managers are documented in a Case Management note in the EMR. However, we do not have the capacity to capture the services needed and the resources provided in categories. To identify the needs of our patients, the Case Managers manually document in an external spreadsheet each day the resources provided to patients.

Next, our Case Manager coordinates care from Labor and Delivery for both mom and baby. UCM-Ingalls reaches out to the CM directly to schedule patients in a timely manner and provide quick responses to ensure patients are discharged with appointments. This has been a positive relationship and continues to grow as we, FCHC, and UCM-Ingalls L&D want to ensure quality care and access for our patients.

In addition to scheduling postpartum and newborn appointments, the Case Manager also reaches out to patients who no show for their Prenatal Care appointments to assess reasoning and to assist with rescheduling to ensure access to care.

Lastly, our part-time Case Manager is responsible for monitoring our high-risk OB referrals and provide additional supportive services to them in collaboration with the full-time Case Manager. Our PT CM follows up to 75 referrals monthly to reach out to patients, educate them on why they are being referred to another office, ensure they have access to get to and from appointments, assist in scheduling and following up with the high-risk office to obtain consult and diagnostic reports. This Case Manager also manages delivery information each month. They conduct outreach calls to the patient and to UCM-Ingalls to identify the location of where the patient delivered, the weight of the baby, the delivery method, the sex of the baby, and if mom and baby scheduled post care visits. This ensures follow-up on post-discharge care for both mom and baby.

Care Integration

This proposal will improve the integration of care by adding support staff to monitor the patient's care throughout their entire pregnancy. This is not a current option for the current team. When a patient is followed at minimum during each trimester, FCHC can increase prenatal care visits, intervene with current social needs, and ensure patients have basic human needs, because life can change through a nine-month period. The efficiency will improve with the added staff. It is our goal to provide responses within 24 to 48 hours. However, with managing many components/projects of OB care, the case manager may need additional time to respond. With the added staff, we can reach our goal of the response time to the patient. Lastly, with the dedicated staff, we will be able to closely monitor patients who may go to the ER, get admitted/discharged, and follow-up to coordinate care from the hospital back to their OB provider. Additionally, with dedicated staff, we will be able to follow-up and increase completion among post-partum appointments and effectively transition our OB population back to their Primary Care Provider after their six-week post-partum visit.

We plan to hire community health workers and Care Coordinators as part of our intervention.

We are collaborating with the following MCOs:

- Access To Care
- Aetna Better Health

- BCBS Medicaid
- Community Care Alliance
- County Care
- IL Youthcare
- Meridian
- Molina

Minority Participation

Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise (BEP) and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners.

Project Management, Black-Owned

Joseph West, ScD
CEO & Founder - Capgenus

Black Woman-Owned Healthy Food and Nutrition Partners:

Sweet Potato Patch
CEO & Founder – Stacey Minor

FruVe X'Press Juicery
CEO & Founder – Dominique Dunn

Black Woman-Led Equity Partners:

Institute of Medicine
President- Dr. Cheryl Rucker-Whitaker

Black Girls Break Bread Inc. 501(c)(3) Nonprofit organization
Co-Founder & President – Jessica Davenport Williams

Housing Referral Partner

Christian Community Health Center (FQHC)
CEO – Kenneth Burnett

Black Woman-Owned Transportation Partner

Amazing Grace Medical Services
CEO – Ayodeji Dairo

Jobs

Existing Employees. For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels.

New Employment Opportunities. *Please estimate the number of new employees that will be hired over the duration of your proposal. Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve. Please describe any planned activities for workforce development in the project*.

Existing Employees. Approximately 60% of employees live in the FCHC service area.

Zip Code	Job Title
60653	Associate Medical Director
60610	Community Nutrition Coordinator
60445	Medical Assistant
60422	Associate Medical Director
60411	Registered Nurse
60443	Patient Service Associate (2)
60653	Psychiatrist
60443	Medical Director
60466	Practice Manager
60409	Care Team Supervisor (2)
60652	Data Specialist
60611	Internal Medicine Physician
60445	Senior Accountant
60423	Nurse Practitioner
60423	Summer Intern 2021
60803	Certified Coding Specialist
46410	Revenue Cycle Analyst
60411	Revenue Cycle Specialist
60426	Referral Coordinator
60443	Grant Writer
60471	Community Health Worker
60527-2967	Family Practice Physician Nurse
60461	Practitioner
60426	Patient Access Representative
60469	Patient Access Representative
60478	REFERRAL COORDINATOR
60406	Patient Service Associate
46410	Lead Referral Coordinator
60461	Licensed Professional Counselor
60803	Patient Access Representative

60443	Pediatric Physician
60443	Medical Assistant
60443	MCH Education & Program Specialist
60620	CREDENTIALING SPECIALIST
60472	Referral Coordinator
60652	Clinical Care Manager
60435	Medical Assistant
60411	Medical Assistant
60431	Certified Coding Specialist
60401	Practice Manager
60406	Patient Access Representative
60411	H.I.M. Clerk
46323	Community Health Coordinator
60615	Chief Executive Officer
60438	Facilities Manager
60429	Dental Assistant
60438	Medical Assistant
60615	Family Practice Physician
60601	OB/G YN Physician
60469	Medical Assistant
60466	Primary Care Case Manager
60628	Medical Assistant
60484	Dental Hygienist
60422	Medical Director
60430	Nurse Practitioner
46322	H.I.M. Clerk
46304	Certified Coding Specialist
60615	OB G YN Physician
60478	Patient Financial Counselor
60425	Associate Dental Director
60438	Dental Assistant
60803	Medical Assistant
60411	Accounting Clerk
60411	Minister of Care
60429	Dental Assistant
60827	Medical Assistant
46410	Revenue Cycle Specialist
60419	Care Team Supervisor
60426	RECEPTIONIST
60430	Director of Development
60477	Nurse Practitioner
60487	Community Health Worker
60443	Pediatric Physician
60409	Medical Assistant
60430	Marketing & Business Development Manager
60473	Clinical Quality Coordinator Assistant

60628	Human Resources Manager
60412	Patient Access Representative
60411	Nurse Practitioner
60473	Medical Assistant
60438	Quality & Training Manager
46320	Revenue Cycle Specialist
60411	Care Coordination Manager
60463	Pediatric Physician
60411	Practice Manager
60614	Pediatric Physician
60649	Quality Outreach Coordinator
60617	Medical Assistant
60633	Medical Assistant
60441	Nurse Practitioner (2)
60429	Maintenance Mechanic
60473	Patient Access Representative
60419	Medical Assistant
60406	OB/PEDS Case Manager
60462	Family Practice Physician
60617	OB/PEDS Case Manager
60426	Community Outreach Supervisor
60430	CFO
60426	Quality Outreach Coordinator
60411	Patient Service Associate
60612	Patient Access Representative
46312	Medical Assistant
60621	Medical Assistant
60422	Associate Medical Director
60827	Medical Assistant
60411	Revenue Cycle Specialist
60827	Patient Service Associate
46324	Lead Patient Services Associate
60411	Medical Assistant
60406	Dental Assistant
60438	Patient Access Representative
60411	Practice Manager
60406	Care Team Supervisor
60461	Dentist
60616	IM/Pediatrics Physician
60426	Patient Service Associate
60652	Nurse Practitioner
60426	Director of Community Health & Programs
60430	Practice Manager
46410	Medical Assistant
60462	OB/GYN Physician
60462	Family Practice Physician

60426	Community Health Worker
60653	Registered Nurse
46342	Senior Revenue Cycle Manager
60477	Patient Access Manager
60515	Pediatric Physician
60619	Director of Human Capital Development

New Employees: Approximately 50% of new employees are anticipated to come from the FCHC service area.

This initiative will hire 25 new employees. To build service capacity, FCHC will hire eight mid-level, two OB/GYNs, PCPs, case managers and community health workers. The expanded provider capacity will increase our ability to meet patient need. The new hires of direct care providers will allow FCHC and the Collaborative to increase annual capacity at least 10% per year. In addition, funding will improve operations and bring much-needed administrative support.

Family Christian Health Center launched its eight-week summer internship program in 2021 to enable college students within the service area who have an interest in community health, public health, and population health to work within a federally qualified health center. The internship program allows students the opportunity to earn a stipend, gain exposure to the field of medicine, and an appreciation for a diverse patient population in South Suburban Cook County while preparing them to add value to the health center via service.

Students were exposed to FCHC's six specialty areas: 1) Family Practice, 2) Behavioral Health, 3) Pediatrics, 4) Obstetrics & Gynecology, 5) Immediate Care and 6) Dental. Students also had the opportunity to work in the FCHC community outreach department which allowed them to go into the community to assist with COVID-19 vaccines, and diabetes, hypertension, and nutrition education. Students within the Maternal Child Health + Wellness Center assisted with streamlining internal communication, scheduling appointments, patient registration, insurance verification, care management and referral to specialists. Students gained hands-on experience with a patient's entire lifecycle at Family Christian Health Center including shadowing providers. As a final project, students were asked to create a presentation detailing discoveries and recommendations for quality improvement to key organizational leadership.

Family Christian Health Center plans to expand the internship program to accommodate 30 interns annually by creating multiple cohorts with a matriculation plan by providing services to facilitate student success, encourage retention, and improve the workforce pipeline of racially concordant healthcare professionals. Over the duration of the proposal, FCHC aims to retain 10% of the total internship population by Year 5.

Quality Metrics

Alignment with HFS Quality Pillars. *Tell us how your proposal aligns with the plans and the overall vision for improvement in the Department's Quality Strategy. Does your proposal align with any of the following Pillars of Improvement?*

HFS Quality Pillar	FCHC Maternal Child Health + Wellness Center Transformational Collaborative
Maternal Child Health	The FCHC Maternal Child Health + Wellness Center Transformational Collaborative addresses historical and systemic healthcare gaps contributing to Illinois maternal and infant mortality. This initiative brings together a network of medical services and direct outreach care to reduce high-risk pregnancies both "upstream" and immediately following delivery.
Adult Mental & Emotional Health	The FCHC Maternal Child Health + Wellness Center Transformational Collaborative addresses urgent needs for specialized maternal and infant peripartum mental and emotional care. This collaborative brings together a coordinated care model for depression and/or anxiety in pregnancy, postpartum depression, and stress, peripartum obsessive-compulsive disorder, parenthood adjustment, family therapy and pregnancy after loss counseling.
Child Mental & Emotional Health	The FCHC Maternal Child Health + Wellness Center Transformational Collaborative addresses urgent needs for individualized, evidence-based, culturally, and linguistically competent mental health services that improve the lives of children and their families. This collaborative brings together providers to integrate services to build resilience and to prevent, severity, duration and disabling aspects of children's mental and emotional disorders.
Equity	The FCHC Maternal Child Health + Wellness Center Transformational Collaborative addresses gaps in access to mobile and digitally enabled care. Our transformation uses mobile applications and technologies to improve outcomes and reduce maternal health costs for high-risk behavioral health, substance use disorder treatment, perinatal care, and ED utilization. We will deploy mobile & digital solutions to improve patient communication, transitional housing placement, Rx meal requests and transportation.
Improving Community Placement	The FCHC Maternal Child Health + Wellness Center Transformational Collaborative addresses community placement through expansion and replication of model to sites set to state border and extending across two counties (East and West, southern Cook and Will). Our work addresses the serious need for emergency and transitional housing for single mothers and families, food insecurity and develops a scalable model of care coordination, data, and surveillance for measuring impact.

Milestones

For all activities described in your proposal please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, when people will be hired, etc.). The timeline should be in months from award.

2022		
Milestone: ▪ Perinatal care planning for mobile application. Launch app development and clinical model mapping for UX / UI app design and user journey map. ▪ App development with Quality Assurance. App production with Continuous Integration: plan, code, build, test (and repeat). ▪ Coordinate and convene OB/GYN, PCP, care teams from each FQHC; Share current capacity, workflows ▪ Hire and onboard maternal and child health clinical managers, case workers ▪ Share population health reports on women of reproductive age	▪ ***6-8 months*** *Back-end architecture; data synchronization, storage capability; AI, unique intelligence* ▪ Wireframing and mockup Framing of functionality and user experience. ▪ Clinical care team has met and outlined clinical metrics and benchmarks specific to addressing high-risk pregnancies ▪ Identify BEP Vendors and launch community BEP information using population health data, define case criteria, examine panels and existing cases for current care, reporting/billing, and follow-up standards ▪ Define metrics available (unavailable but needing development) for care gaps ▪ Define levels of care workflows, referral needs and processes	▪ ***9-12 months*** *Front-end architecture; render the app's appearance & user-interface; Resource & Network Integration* ▪ *Housing, transportation, and social service mapping for app framework. All MOUs, contracts and agreements are in place.* ▪ *All stakeholders have been convened to evaluate and test the application framework, clinical use, and impact of workforce.*
2023		
Milestone: ▪ Launch app development and clinical model mapping for UX / UI app design and user journey map. ▪ App development with Quality Assurance. App production with Continuous Integration: plan, code, build, test (and repeat). ▪ In app features: Standardize how and where patients are	▪ ***Prototype ready.*** *Phase I Launch. Testing and feedback (16-weeks); Resource & Network Integration: back-end PHM analytics* ▪ In app features for clinical prenatal labor & delivery postnatal processes have been updated, clearly communicated to the team and ready for launch. ▪ Set in –app prenatal labor & delivery postnatal milestones clinical processes (e.g., patient hand-offs, post discharge follow-	▪ ***Prototype ready.*** *Phase II Live Launch; Resource & Network Integration* In-app features address housing, food suppliers, income support services, transportation, and social support services ▪ In-app features shared care planning and care coordination tools to integrate community-centered family planning and postpartum care efficiently and effectively

referred to appropriate level of care and/or wrap around services	ups) will be completed because of the proposed intervention.	
2024		
Milestone: ▪ Compatibility and user testing with population. Running app on different devices and screen sizes. Interface testing - checking the navigation, menu, and button performance. Security testing - quality assurance of sensitive data safety.	▪ **Finalization.** Back-end maintenance, data storage and analysis; Front-end user experience improvements ▪ Measuring patient use and user experience with app. ▪ Integrate family planning and systems of care for risk reduction and better prenatal care.	▪ ***Planning Replication and* Scale** and deployment; *Resource & Network Integration & Marketing; User satisfaction, usability, and outcomes of use* ▪ In app feature: Access to preventable (ambulatory) health services ▪ In app feature helping manage chronic care conditions ▪ In app features helping connect patient to grief/loss counseling
2025		
Milestone: ▪ Measures on maternal health, fetal mortality, and other population metrics ▪ User data on frequency, types of service, areas of need, user satisfaction, uptake metrics. ▪ Security and device testing continuation. Population health reports.	▪ The population health and surveillance team have integrated capability for exchange of patient care data across targeted patient care delivery settings and networks (including 9-1-1 system, hospital ED, urgent care centers, physician offices and medical home).	▪ ***State-wide Planning* Scale** and deployment; *Resource & Network Integration; Cook, Will, DuPage, Winnebago, Kankakee County reach*

Sustainability

Include a narrative that describes how your budget will decrease reliance on Transformation funding over time and how reimbursements for services and other funding sources will increase and establish sustainability over time (i.e., how will your project continue to operate without HTC funding?).In particular, include how services that address social determinants of health will be funded on an ongoing basis (for example, through existing payment models, alternative payment methodologies for Medicaid services, or through other funding sources). In your narrative, highlight any key assumptions that are critical to making your project sustainable.

Payment models for Medicaid providers, especially for those caring for the highest risk patients, must evolve. Technology use and innovations in wearables and communication can help reduce patient risk, increase provider productivity, and transform the Illinois healthcare system. Sustainability of this effort requires cooperation, alignment, and communication between every facet of Illinois healthcare. All healthcare stakeholders including patients, healthcare workers, hospitals, social insurers, and policymakers must be engaged to sustain the advancement of technology and innovation. Over the five-year period, FCHC will develop a financial model for fully supporting reimbursement for mHealth and telehealth services for all Medicaid eligible populations. FCHC Maternal Child Health + Wellness Collaborative will continue to advance work with the MCOs for alternative payment methodologies and opportunities for value-based care payments. We will continue to seek funding for maintaining the platform, using data and findings to validate the strengths of the model. This work is anticipated to significantly increase our patient volume and subsequent revenue. Most of the funding is going directly towards strengthening provider resources and enhancing service capacity. This will be sustainable through billing. These funds will be reinvested in practitioners, in MHealth and telehealth systems and in providing services directly to patients.

Our data, and that of other FQHCs and hospitals are showing that Illinois is losing patients to outmigration to Northwest Indiana. These are patients that reside in Southside of Chicago, South Suburban Cook and Will counties. FCHC Maternal Child Health + Wellness Collaborative aims to better serve Illinois families, so they don't abandon the state for much need care and follow-up.

Our focus remains on value-driven rather than on volume-driven healthcare. Sustainability can be supported through state enacting a telemedicine parity law. Our work will help further payer cooperation in the state requiring reimbursement for mHealth and telehealth coverage in the same manner as they do with in-person care. However, much work and new thinking remains. FCHC is committed to building on concrete examples that demonstrate tangible savings can be realized through investment in technology, education of technology use, building workforce capacity to provide remote and mobile care, prevention, and early intervention. Illinois' investment in FCHC Maternal Child Health + Wellness Collaborative will encourage higher pursuit of quality across the spectrum of Medicaid eligible care, encourage and reward innovation, and elevate improved patient outcomes as a priority in reimbursements and managed care.

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Napoleon B. Harris III

Majority Caucus Whip
15th Legislative District

November 19, 2021

Lisa Green, DO, MPH
Chief Executive Officer & Co-Founder
Family Christian Health Center
31 W. 155th Street
Harvey, IL 60426

RE: FCHC Healthcare Transformation Collaboration

As State Senator of the Legislative 15th District, I am pleased to support Family Christian Health Center ("FCHC")'s application for a 5-years of healthcare transformational funding to strengthen services through staffing and the development of a mobile application (**MHealth solutions**) within a newly created standalone Maternal Child Health + Wellness Center.

To many individuals, "suburbs" suggests wealth and affluence. However, there are 16.9 million Americans living in poverty in the suburbs -more than in cities or rural communities. Despite the rise in suburban poverty, there has been little research into health care barriers faced by residents in these areas.

Family Christian Health Center, a federally qualified health center located in Harvey, Illinois was founded in 2000. Since then, it has witnessed first-hand, the migration pattern of the Southland communities. The problems that existed 20 years ago have been exacerbated by the demolition of Chicago's public housing. In February 2020, Dr. Lisa Green, along with a group of Black women physicians and nonprofit leaders began addressing health disparities and unique challenges of the birthing population on the South Side of Chicago and South Suburban Cook County; amid an alarming trend of hospitals discontinuing inpatient obstetric services and an unprecedented global pandemic. Family Christian Health Center (FCHC) is located within Illinois Hospital Planning Area A-04, but has patients who also span across Illinois Hospital Planning Area A-03, as it services nearly 20,000 patients across 59 zip codes.

Since 2019, residents living in both hospital-planning areas have experienced the discontinuation of labor and delivery services in four hospitals impacting over 300,000 reproductive age persons residing in those regions. For the city of Harvey, IL, there are no perinotologists or neonatologists. High risk pregnant patients must travel between 10 to 24 miles to receive advanced maternal care or neonatal care for infants.

This proposal seeks 5-years of transformational funding to strengthen services through staffing and the development of a mobile application (MHealth solutions) within a newly created standalone Maternal Child Health + Wellness Center. This proposal is transformational and relevant to public health and health services in Illinois by addressing:

a. the profound historical and systemic healthcare gaps contributing to Illinois being ranked 33rd out of 50 states in maternal and infant mortality (Maternal Health);
b. the need to bring together a network of medical services and direct outreach care to reduce high-risk pregnancies both "upstream" and immediately following delivery (Maternal Health);
c. services needed to address emergency and transitional housing, substance abuse and postpartum depression and prenatal emotional distress (Mental Health Parity); and
d. the need to develop a scalable model of care coordination, data, and surveillance for measuring impact, and population health information technology (Access and Health Equity).

As a means for enhancing healthcare delivery through telecommunications devices, telehealth encompasses multiple healthcare disciplines, including maternal and child health. It includes live videoconferencing as well as remote patient monitoring and mobile health (mHealth). The greatest benefit of telehealth is expanded access to care, particularly for patients in poor, isolated, and geographically segregated locations who must otherwise travel extended distances for care.

Other benefits include cost savings, improved workflows, enhanced communication between the clinician and patient, and improved health literacy and patient self-management with physician feedback.

The MHealth application (app) will close the technology and innovation equity gap by bringing preventive care, prenatal care, postnatal care, and family system supports right into the palm of patients' hands. The application will allow patients to connect with obstetrics and pediatrics, postpartum care, mental & behavior Health (including grief and loss counseling), pharmacy, benefits & family planning, food and nutrition and emergency & permanent housing right from their smartphone, tablet, and other mobile device.

<u>The advances in mobile technologies and applications are driving the transformation in health services delivery globally. Our communities cannot afford to be left behind on technological investment, innovation, and use.</u>

I share Family Christian Health Center's mission of improving health outcomes and providing patient-centered care to those who are medically underserved. Therefore, I fully support the efforts of Family Christian Health Center as they seek healthcare transformational funding to strengthen services through staffing and the development of a mobile application (MHealth solutions) within a newly created standalone Maternal Child Health + Wellness Center. I stand with them in helping to care for the underserved in the community at large.

Sincerely,

Napoleon B. Harris III